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Welcome to "Washington Update," the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Matt DoBias
Vice President, Congressional Affairs
mdobias@apg.org

Jennifer Podulka
Vice President, Federal Policy
jpodulka@apg.org

Garrett Eberhardt
Executive Director, Medicaid Policy
geberhardt@apg.org

Greg Phillips
Director of Communications
gphillips@apg.org

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Senate Panel Examines Drivers Behind Consolidation

A confluence of economic factors has driven consolidation across independent group practices, but value-based care arrangements could slow the trend within primary care in particular, key experts told members of the Senate Finance

Committee this week. Their comments came amid a hearing examining consolidation and "corporatization" within health care, trends that have elicited growing bipartisan concern in both the House and Senate.

Shawn Martin, executive vice president and chief executive officer of the American Academy of Family Physicians, told the Finance Committee that newer payment models that moved beyond relatively low fee-for-service payment could slow the consolidation trend among primary care practices. "Alternative payment models, when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that provide the financial flexibility or provide truly patient-centered care," he said.

Ranking committee member Sen. Mike Crapo (R-Idaho) concurred that low Medicare payment was a fundamental spur to consolidation. The payment system, he said, "has prompted waves of retirements and made independent practice untenable for far too many frontline providers."

Wide-ranging testimony at the hearing also discussed other factors driving consolidation, including higher payments for procedures performed in hospital outpatient settings versus in a physician's office. Despite the hearing's title, little was said to advance understanding of what constituted "corporatization" in health care, beyond a focus on past purchases of health care entities by private equity concerns.

Beyond a move to site-neutral payments, it's unclear at this point what legislative proposals to address consolidation will end up in a broad package of health-related measures likely to advance in Congress this year. APG will continue to monitor, shape, and report on legislative developments as they occur.

CMS's Innovation Center Introduces New Primary Care Model

More small primary care practices could take steps to embrace value-based care under a new "Making Care Primary (MCP)" model introduced this week by the Center for Medicare and Medicaid Innovation (CMMI). The model builds on lessons learned from prior primary care models, such as Comprehensive Primary Care Plus (CPC+) and Primary Care First.

MCP will begin on July 1, 2024, and is planned to run for 10 years in eight states: Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington. MCP will offer three tracks tailored to participants' degree of experience with value-based care, including one in which payment will remain fee-for-service, but enable new entrants into value-based care to develop the capacity and infrastructure to deliver advanced primary care. The other two tracks of the model will offer partial or full prospective payments for primary care. MCP will also include Federally Qualified Health Centers (FQHCs) and incorporate both state Medicaid programs as well as commercial payment.

In a statement, APG said it welcomed CMMI's efforts to test the model. "Long-term models such as this one," said APG's President and CEO, Susan Dentzer, "will offer stability to participants and may therefore ensure greater participation. APG's members are value sophisticates, and we look forward to one day welcoming veterans of the Making Care Primary model into our membership ranks once they have mastered the basics of value and can flourish in that environment."

CMS Creates New Medicaid Managed Care Group to Oversee Program

A new Managed Care Group within CMS's Center for Medicaid and CHIP Services will take the lead on Medicaid managed care access and accountability issues, CMS announced this week. The new group will conduct oversight on managed care 1115 waivers, 1915(b) waivers, and 1932(a) state plan amendments, as well as review and approve of new managed care programs.

The creation of the group follows recently proposed rules from CMS aimed at ensuring access to Medicaid managed care, as well as new payment transparency requirements within managed care programs. These rules, and other issues affecting Medicaid managed care organizations (MCOs), will have either direct or indirect impact on APG members that contract with MCOs to provide services to Medicaid beneficiaries.

The creation of the new Managed Care Group comes at a time when more than two-thirds of all Medicaid beneficiaries now receive most or all of their care from risk-based MCOs, according to the Kaiser Family Foundation's Medicaid Managed Care Tracker. MCOs "in turn contract with state Medicaid programs to deliver comprehensive Medicaid services to enrollees, and are increasingly expanding to serve more medically complex beneficiaries," the tracker notes.

Disparities Seen in COVID-Era Care for Disabled and Financially Needy Medicare Advantage Enrollees

Medicare beneficiaries with financial needs and disabilities are more likely to opt for Medicare Advantage (MA) over traditional, fee-for-service (FFS) Medicare, a new report from CMS's Office of Minority Health confirms. But based on an analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data for 2020, these populations enrolled in MA plans experienced below-average care in such areas as cancer screening, care for mental illness, care coordination, and overuse and appropriate use of medication, the report shows.

The analysis, conducted by RAND Health, focused on MA enrollees who were either dually eligible for Medicare and Medicaid, eligible for a Part D Low-Income Subsidy (LIS), and/or disabled, meaning that their disabilities were the original reason they became qualified for Medicaid. It did not compare these MA enrollees to enrollees in traditional Medicare, since comparable HEDIS data is not collected about people in the traditional FFS Medicare program. Rather, the report illuminates care disparities for MA beneficiaries with financial needs or

disabilities when compared to the national averages for people enrolled in MA plans.

The report noted that the greatest disparities were apparent in people whose disabilities were the original reason they became qualified for Medicare, versus those who were dually eligible for Medicare and Medicaid or who qualified for the LIS subsidy. It also noted that, because the data evaluated corresponded to care received in 2020, the results probably “reflect the influence of the coronavirus disease 2019 (COVID-19) pandemic, [which] had an unprecedented impact on the health care system” and, presumably, these populations’ access to care during that period.

Beyond the implications of the pandemic, left unanswered by the analysis is a full understanding of what drove the disparities observed, the RAND report noted. And given the absence of HEDIS data for traditional Medicare, it remains unclear to what extent disparities in MA differed from those in the FFS portion of the program during the same time period.

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